VENTURA ADVANCED SURGICAL ASSOCIATES
Helmuth T. Billy, MD

Thank you for considering Ventura Advanced Surgical Associates as your healthcare provider. As part of our commitment to our patients we strive to provide the highest standards in the evaluation and treatment of our patients. In order for us to meet those standards it is imperative that we obtain a detailed medical history from each of our patients. Attached to this letter is our medical history and evaluation form that you will need to complete in order for us to completely understand your medical history. You will only need to complete this form once.

Please take the time to address and answer each question as they are all important in completing your evaluation. The entire document will be reviewed with you at your initial consultation and will continue to provide important information for our physicians and nurses throughout your evaluation.

Our patient history form includes a comprehensive sleep questionnaire. Obesity increases the risk of sleep apnea which may cause or exacerbate diabetes and hypertension. Sleep apnea may also increase the risk of postoperative complications. If we determine that you have sleep apnea, we will initially treat the condition prior to any surgery to decrease your risk of postoperative complications. With weight loss most patients with sleep apnea improve or are cured, however some patients with sleep apnea are not overweight and it is therefore an important set of questions to consider in all our patients. Please take the time to answer the simple yes and no questions asked in our sleep evaluation.

Once we have a complete medical history and sleep questionnaire we can proceed with your initial evaluation.

Thank you from the staff of Ventura Advanced Surgical Associates.

3200 Telegraph Road, Ventura, CA 93003
www.drbillybariatrics.com
805.676.9100

NEW PATIENT INFORMATION

Date of Birth:_____Sex:____Social Security Number:_____
Mailing Address:_____
City:_____State:_____Zip Code:_____
Home Phone:_____Work Phone:_____
Cell Phone:_____Driver's License Number:_____
Email Address:_____Emergency Contact: _____
Referring Physician Name and Phone Number:_____
Employer:_____
Employers Address:_____
City:_____State:_____Zip Code:_____
Spouses Name: _____
Spouses Employer:_____
Employers Address:_____
City:_____State:_____Zip Code:_____
Work Phone:_____Occupation:_____

Insurance Information:
Insurance Card Holder: _____
Social Security Number of Cardholder:_____Date of Birth: ___
Employer:_____
Employers Address:_____
City:_____State:_____Zip Code:_____

Private Insurance:

1. Company:_____ Group Number: _____
   Address:_____Subscribers Number:_____
   (please provide a copy of your driver's license)

2. Company:_____ Group Number: _____
   Address:_____Subscribers Number:_____
   (please provide a copy of your driver's license)

   Medicare number:_____

Work Related Injury? Yes No Date of Injury: _____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to Helmuth T. Billy,MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

BILLING POLICY STATEMENT

Dear Patient,

It is the policy of our office to collect any deductible, co-payment and/or co-insurance amounts prior to any elective surgery. When you make the final decision to schedule surgery, the billing department will call you and notify you of the amount you will need to prepay.

Since insurance quotes are sometimes inaccurate, you may owe additional money or be entitled to a refund from our office after the insurance company processes the charges. In any case, we will send you a bill or refund promptly. Please ask for clarification on any information regarding this policy prior to your surgery, so as to avoid confusion later.

We schedule our appointments so that each patient receives the right amount of time to be seen by Dr. Billy and/or clinicians. It is very important that you keep your scheduled appointment with us and arrive on time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you and accommodate those patients who are waiting for an appointment. As a courtesy to our office, as well as to those patients who are waiting, please contact us at least 24 hours in advance.

If you do not cancel or reschedule your appointment with us, there is a $25 "no-show" service charge added to your account. This "no-show" charge is not reimbursable by your insurance company. You will be billed directly for it.

Patient:_____

Signature:_____

Date: _____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatment needed to restore your health. If you have any questions or concerns about our payment policies, please do not hesitate to ask our office staff.

We ask that all patients complete our patient information forms prior to seeing the doctor, as well as reading and signing our financial policy.

Payments for services done in our office are due at the time they are rendered. We bill your insurance company for you. If you do not have any insurance, we will bill you directly.

You must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. This office is NOT a party to that contract. Our relationship is with you and not your insurance company.

2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. If the insurance company does not pay in full within sixty days, we require you to pay the balance due with cash, check, or credit card.

4. Returned checks and balances older than 45 days may be subject to additional collection fees and interest charges of 2 1/2 percent per month.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient/Responsible Party:_____ Date:_____

HIPAA PRIVACY AUTHORIZATION

FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (collectively known as HIPAA).

Our notice of Privacy Policy provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Policy before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Policy. You obtain a copy of the current notice by requesting it from our staff.

You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment, or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to us, either personally or by mail. It will be effective when we receive it.

I hereby give consent to Helmuth T. Billy M.D., or Andrew S. Binder M.D. to use and disclose my protected health information for the purpose of treatment payment and health care operations.

Patient signature:_____**Date:**_____
Print name of patient:_____**Date:**_____

If you are signing as the patient's representative:
Print your name:_____**Date:**_____
Describe your authority:_____

<u>Revocation</u>

I hereby revoke the consent given above.

Patient signature:_____**Date:**_____
Print name of patient:_____**Date:** _____

If you are signing as the patient's representative:
Print your name:_____**Date:**_____
Describe your authority:_____

MEDICAL HISTORY QUESTIONNAIRE

Patient Name:_____Date: _____
Date of Birth: _____

REASON FOR VISIT

Are you here for evaluation of possible weight loss surgery? Yes No

Does your weight problem cause any of the following?

Fatigue	Yes	No
Diabetes	Yes	No
High Blood Pressure	Yes	No
Arthritis	Yes	No
Snoring	Yes	No
Obstructive Sleep Apnea	Yes	No

If yes to Obstructive Sleep Apnea, have you had a sleep study? Yes No
If yes to Obstructive Sleep Apnea, do you use a CPAP machine? Yes No

Describe any other problems or reasons for visit:

_____

_____

_____

_____

ALLERGIES

Are you allergic to any medications? Yes No

If yes, please list medication and the reaction.

Drug_____ Reactions_____

Drug_____ Reactions_____

MEDICATIONS

Name of Drug	Dosage	Doses Per Day

Patient Name: _____ **Date:** _____

I have had the following medical problems:

Problem	Year of Diagnosis	Management/Special Care/Misc.

FAMILY HISTORY

Father
Age_____
Living_____Dead_____
Cause of Death_____
Any Medical Problem?_____
_____

Mother
Age_____
Living_____Dead_____
Causes of Death_____
Any Medial Problems?_____
_____

Number of Children_____ Ages_____

Living__ Deceased_____ Cause_____
Any Health Problems in your children? Yes No

Siblings

Brother	Living	Deceased	Age	Cause of Death	Medical Problem
Sister	**Living**	**Deceased**	**Age**	**Cause of Death**	**Medical Problem**

Have any family members ever had?

Cardiac Disease/Heart Attacks	Yes	No	Anesthetic complications	Yes	No
Lung Disease	Yes	No	Other Disease	Yes	No
Cancer (location)	Yes	No	Thyroid disorders	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
High blood pressure	Yes	No	Bleeding disorders	Yes	No

If so, state whom and as what age:

_____
_____
_____
_____

Patient Name: _____ **Date:** _____

SOCIAL HISTORY

Single	Yes	No	
Married	Yes	No	How many years? _____
Widowed	Yes	No	
Divorced	Yes	No	

Occupation: _____

HABITS

Tabacco

Do you smoke? Yes No Cigarettes/day _____ Years_____
Did you smoke? Yes No Cigarettes/day _____ Years_____
When did you quit?_____
Do you use E-Cigarettes? Yes No
When was your most recent tobacco use screening? _____

Alcohol

Do you drink alcohol? Yes No Drinks per day? _____

Caffeine

Do you drink coffee, tea, soft drinks? Yes No Cups of coffee per day? _____
Sodas per day? _____

Other Substances

Do you use or have you ever used any recreational drugs? Yes No
(This information will be maintained strictly confidential)

Please list or explain: _____

I have had the following SURGICAL procedures:

Procedure	Year	Comments

Have you had your tonsils and/or adenoids removed? Yes No

Patient Name: _____ **Date:** _____

I have been involved in the following accidents:

Accident	Year	Injury

List hospitalizations (other than for elective surgeries):

Date	Reason

REVIEW OF SYSTERMS

Please circle **yes** or **no** to each following diseases, symptoms, or conditions.

General:

Yes No Problem with anesthesia
Yes No Significant weight loss, not associated with dieting.
How much in the past year?_____
Yes No Significant weight gain.
How much in past year?_____
Yes No Night sweats
Yes No Fever
Yes No Chills

Head, Eyes, Nose, throat (HEENT):

Yes No Eye: blurred vision, double vision, "blackouts"
Yes No Ear problems: poor hearing, ringing / buzzing in ears, infections, drainage
Yes No Sinus problems: stuffy nose, runny nose, hayfever
Yes No Cancer or other diseases of the oral cavity
Yes No Change in voice, hoarseness

Cardiovascular:

Yes No Chest pain ("angina") / Heart attack
Yes No High Blood Pressure
Yes No Murmur
Yes No Pacemaker
Yes No Palpitations
Yes No History of abnormal EKG or hear study
Yes No Congestive heart failure (CHF)
Yes No Foot or ankle swelling
Yes No Disease of peripheral blood vessels (arteries or veins–phlebitis) of the arms, legs or brain

Patient Name: _____ Date: _____

Respiratory:

Yes	No	Difficulty breathing / shortness of breath
Yes	No	Snoring
Yes	No	Observed pauses in breathing during sleep
Yes	No	Pneumonia
Yes	No	Bronchitis
Yes	No	Emphysema
Yes	No	Cough
Yes	No	Wheezing
Yes	No	Blood clots in legs or lungs
Yes	No	Lung cancer
Yes	No	Asthma
Yes	No	Coughing up blood
Yes	No	Feeling of smothering when you lie down or are awakened from sleep
Yes	No	Other pulmonary disease _____

Gastrointestinal (GI):

Yes	No	Heartburn
Yes	No	Stomach ulcer disease
Yes	No	Nausea / Vomiting
Yes	No	Vomiting, spitting, or coughing up blood
Yes	No	Diarrhea, constipations, blood in bowel movements
Yes	No	Inflammation of the pancreas
Yes	No	Hepatitis or liver problems / Jaundice (yellow skin or eyes)
Yes	No	Spleen disease, "easy bleeding"
Yes	No	Abdominal problems: stomach pain
Yes	No	Disease of the Small or Large Intestine
Yes	No	Colon Polyps or Cancer
Yes	No	Intestinal bleeding / Blood in Stool / Hemorrhoids

Genitourinary (GU):

Yes	No	Do you get you at night to urinate? How many times_____
Yes	No	Kidney infections or stones
Yes	No	Renal insufficiency or failure (Dialysis)
Yes	No	Urinary Infections
Yes	No	Incontinence
Yes	No	Frequency
Yes	No	Difficulty / pain with urination
Yes	No	Prostate problems
Yes	No	Change in libido
Yes	No	Erectile dysfunction

Musculoskeletal:

Yes	No	Back pain / pain or numbness which extends down to buttocks and/or legs
Yes	No	Joint pain and/or swelling (hips, knee, ankle, hands neck or other)

Dermatologic (skin):

Yes	No	Skin rash (including yeast infections of skin folds)
Yes	No	Skin Lesions
Yes	No	Psoriasis, eczema

Patient Name: _____ Date: _____

Neurologic:

Yes	No	Brian disease or head injury
Yes	No	Seizure disorder
Yes	No	Dizziness, lightheadedness, or fainting spells
Yes	No	Headaches
Yes	No	History of stroke
Yes	No	History of Parkinson's Disease
Yes	No	Peripheral neuropathy
Yes	No	Memory problems
Yes	No	Change or decrease in thinking ability, attention
Yes	No	Other neurologic symptoms or problems_____

Psychiatric/Mood:

Yes	No	Mood change or difficulties
Yes	No	Depression, suicidal thoughts or actions
Yes	No	Anxiety
Yes	No	Bipolar disorder
Yes	No	Other psychiatric problems or diagnoses _____

Endocrine:

Yes	No	Thyroid problems (overactive or underactive)
Yes	No	Diabetes _____insulin dependent
Yes	No	Hormone replacement therapy

Hematologic/Lymphatic/Oncologic (blood, cancer):

Yes	No	Anemia
Yes	No	Enlarged Lymph Nodes (Glands)
Yes	No	Excessive or prolonged bleeding from cuts or dental procedures
Yes	No	Cancer (not previously listed) _____

Gynecologic (GYN):

Yes	No	Breast disease, cancer, lumps, pain, discharge (leakage)
Yes	No	Uterine, ovarian, menstrual, pregnancy problems

My Primary Physician is:

Name: _____
Address: _____
Phone: _____

I see the following specialists:

Name: _____
Address: _____
Phone: _____

I see the following specialists:

Name: _____
Address: _____
Phone: _____

I see the following specialists:

Name: _____
Address: _____
Phone: _____

Patient Name: _____ **Date:** _____

BARIATRIC HISTORY (Please circle yes or no to each following)

Are your parents' overweight? **Mother** Yes No **Father** Yes No
Are your siblings overweight? **Sister** Yes No **Brothers** Yes No
Which relatives are morbidly obese? _____
Your obesity started at which stage of life?

Childhood	Puberty	Adulthood	Post Pregnancy	Post Traumatic Event	Other

Where you overweight as a teenager? Yes No If so by how many pounds?_____

Did you employ any weight loss methods? Yes No
If so what type? _____

My weight as an adult has ranged between _____pounds and _____pounds
My most stable weight as an adult has been_____pounds at age _____
I maintained this weight for _____years, _____ months

My current weight is _____pounds
My realistic goal weight is _____pounds
I felt best at a weight of _____pounds when I was _____years of age

Eating Patterns: (Please circle all that apply)

Potions:	Large	Medium	Small	
Type:	Normal	Healthy	Fast Food	Junk Food
Taste Preference:	Sweet	Salty	Comfort Foods	Other

Number of meals per day: _____ Number of Snacks per day: _____
I eat extra calories due to: (Please circle all that apply)
Stress Boredom Sweet Craving Snacking Closet Eater Binging

I have participated in the following Weight Loss Programs/Diets/Medications: (Please circle all that apply)

Conventional ("self") dieting (limiting Calorie intake)

Medifast	Meridia	Redux	Phen-Fen	Schick Center
NutraSystem	Weight Watchers	Jenny Craig	Slim Fast	Diet Center
Metabolife	Optifast	Atkins	Lindora	Diet Pills
Cambridge	Sansum Wellness	Xenical	Jaw Wiring	Hypnosis
Acupuncture	Protein Diet	Medically Supervised Weight Loss Clinics		

Overeaters Anonymous
Other _____

Do you have any of the following weight related medical problems?

Diabetes: Yes No When Diagnosed: _____
What kind of diabetes? _____
How do you control your diabetes? (Please circle all that apply)
Diet Oral Medications Insulin Nothing

Patient Name: _____ **Date:** _____

How often do you check blood sugars?_____Average blood sugar?_____(am)_____(pm)
Complications? _____

Blood Lipids: Have you ever been told that your cholesterol or triglycerides were too high?

High Cholesterol? Yes No How High_____ What is it now_____
High Triglycerides? Yes No How High_____ What is it now_____
How are/were these conditions treated? (Please circle all that apply)
Diet Oral Medications Not Treated

High Blood Pressure: Yes No When Diagnosed: _____

How do you control your high blood pressure? (Please circle all that apply)
Diet Oral Medications Exercise Nothing
What is the highest blood pressure that you can recall? _____
Most recent blood pressure: _____Complications: _____

Gallbladder:

Has your gallbladder been removed? Yes No Date_____
Do you have gallstones now? Yes No
Have you had an ultrasound of the gallbladder? Yes No Results _____
Do you get gas, bloating, nausea or cramps after eating fried or fatty foods? Yes No
How often? _____
Who in your family has had gallstones? Please List: _____

Heartburn: Yes No When does it occur?_____

How often does it occur? _____How many years? _____
Is it mainly with certain foods? Yes No
If yes, list those foods: _____
Does it awaken you at night? Yes No How often? _____
Do you have pain? Yes No How often? _____
Do you ever awaken coughing and chocking with regurgitations? Yes No
How often? _____
Do you ever regurgitate solid food? Yes No
What time of day does that occur? _____
How do you treat these problems?
Restricted Diet: _____Oral Medications: _____
List any Medications: _____
Complications? (asthma, pneumonia, laryngitis) Please list:_____
_____
Have you ever had an upper GI study or endoscopy? Yes No
When: _____Result: _____

Patient Name: _____ Date: _____

WEIGHT LOSS HISTORY

THIS FORM WILL GO TO YOUR INSURANCE COMPANY
PLEASE BE AS COMPLETE AS POSSIBLE

Date Listed in Chronologic Order	Weight Loss Episode / Attempt What kind? Supervised by whom? Medicine?	Beginning Weight	Amount of Weight Loss	Over How Many Months/Years	Weight Gained Back	Over How Many Months/Years

We know you can't remember every diet you've ever been on. Diet history is very important to gaining insurance approval and/or qualifying for surgery. Please do the best you can. Please continue on the back if necessary.

Patient Name: _____ **Date:** _____

GENERAL

Do you have problems with sleep?	Yes	No
Are you a light sleeper and easily awakened?	Yes	No
Are you tired and/or sleepy during the day?	Yes	No
Have you had an accident or near accident because of sleepiness?	Yes	No
Does sleepiness affect your work or personal relationships?	Yes	No

SLEEP SCHEDULE

Do you do shift work or work a shift at night? Yes No

Workdays

What time do you like to go to bed? _____

What time do you usually wake up? _____

For how long do you usually sleep? _____

Do you use an alarm clock? Yes No

Weekends or non-workdays

What time do you like to go to bed? _____

What time do you usually wake up? _____

For how long do you usually sleep? _____

Do you use an alarm clock? Yes No

Do you ever "sleep in" late?	Yes	No
Do you have trouble falling asleep?	Yes	No
Do you wake up during the night?	Yes	No

If yes, how many times: _____

How long will you be awake? _____

SLEEP RELATED BREATHING DISORDERS (SLEEP APNEA):

Do you snore?	Yes	No	
Do you stop breathing while asleep? (observed by you or a partner)	Yes	No	Not Sure
Do you have or are you treated for high blood pressure?	Yes	No	Not Sure
Do you have heartburn or are you treated for reflux?	Yes	No	Not Sure
Are you overweight?	Yes	No	
Have you had atrial fibrillation?	Yes	No	
Do you wake up gasping or choking?	Yes	No	
Have you lost your bed partner because of snoring?	Yes	No	
Do you have morning headaches?	Yes	No	
Do you wake up with a dry mouth?	Yes	No	
Have you been told your limbs lick or twitch?	Yes	No	

INSOMNIA:

Do you have problems getting to sleep? Yes No

How long does it take? _____

How many nights per week? _____

Do you have problems staying asleep? Yes No

How long does it take to get back to sleep? _____

How many nights per week? _____

Do you wake up too early and have difficulty getting back to sleep?	Yes	No
Do you feel refreshed or restored by sleep?	Yes	No
Are you depressed or anxious?	Yes	No

Patient Name: _____ **Date:** _____

Are you or have you been treated for depression or anxiety?	Yes	No
Do you sleep better in an unfamiliar bedroom such as a hotel room?	Yes	No
Do you have aching, uncomfortable or squirmy sensation in your legs which keep you from sleeping?	Yes	No

For how long have you had problems with insomnia? _____

SLEEP HYGIENE:

Do you eat before bed?	Yes	No
Do you have a desk in your bedroom?	Yes	No
Do you sleep with the TV on?	Yes	No
Do you sleep with a child or animal in your bed?	Yes	No
Do you sleep with lights on or open windows?	Yes	No
Do you have an exercise program?	Yes	No
Do you sleep in a cool bedroom?	Yes	No

SLEEP RELATED MOVEMENT DISORDER (Restless legs/Periodic Limb Movements):

Do you have an unpleasant sensation in your legs associated with an irresistible urge to move?	Yes	No
Does the urge to move/unpleasant sensation begin or worsen during Inactivity?	Yes	No
Do you have unpleasant sensations in the limbs that go away with movement?	Yes	No
Do you kick or jerk your legs during the day/evening/while asleep?	Yes	No
Do you grind your teeth at night, or have you been diagnosed with TMJ?	Yes	No

PARASOMNIA:

Do you act out vivid violent dreams?	Yes	No
Do you ever arouse from sleep confused?	Yes	No
Have you ever hurt yourself or others during sleep?	Yes	No
Have you had arousals during sleep of which you have no memory?	Yes	No
Have you done strange things during sleep during times of stress?	Yes	No
Do you sleepwalk without remembering it?	Yes	No
Do you cry out or scream during sleep?	Yes	No
Do you act out your dreams and are you able to recall them?	Yes	No

EXCESSIVE DAYTIME SLEEPINESS:

Are you sleepy or tired all day?	Yes	No
Do you fall asleep watching TV or reading?	Yes	No
Have you fallen asleep at inappropriate or unexpected times, such as meetings, conversations or social gatherings?	Yes	No
Have you had accidents or near accidents because of sleepiness?	Yes	No
Have you "come to" or suddenly become alert and found yourself doing things without being aware of having started them or remembering how you got there?	Yes	No
Have you experienced sudden weakness in the legs, arms, face, neck or		

Patient Name: _____ **Date:** _____

body in general while awake; perhaps after laughing at a joke or being surprised, angry or upset?	Yes	No
Have you had hallucinations or dream like images while awake?	Yes	No
Have you had hallucinations or dream like images while falling asleep?	Yes	No
Do you take naps during the day?	Yes	No
How many days a week? _____		
How long are the naps? _____		
Are they refreshing?	Yes	No
Do you dream during naps?	Yes	No
Did you fall asleep or fight the urge to fall asleep in school as a child?	Yes	No
Have you ever felt unable to move upon going to sleep or awakening?	Yes	No
If yes to any of the above, have the symptoms been present for more than 8 months?	Yes	No

Spouse, Roommate, or Bed partner Questionnaire:

IMPORTANT! Below should be filled out about you by your spouse, roommate, or bed partner; not about your spouse, roommate, or bed partner)

Does he/she snore?	Yes	No
Does he/she stop breathing?	Yes	No
Does his/her legs or body twitch or kick?	Yes	No
Does he/she grind their teeth?	Yes	No
Does he/she walk in their sleep?	Yes	No
Does he/she sit up in bed while not awake?	Yes	No
Does he/she become rigid or shake during sleep?	Yes	No
Does he/she rock or hang their head during sleep?	Yes	No

Other observations:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name: _____ **Date:** _____

EPWORTH SLEEPINESS SCALE:

How likely are you to doze off in the following situations (in contrast to just feeling tired)? Even if you have not done some of these things, try to work out how these situations would affect you. Use the below scale.

0 would never doze
1 slight chance of dozing
2 moderate chance of dozing
3 high chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in public place (e.g. a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
Total	_____

Graduated Apnea Screening Protocol (GASP) Questionnaire Sleep Evaluation	1	0	1
Have you been told, or noticed on your won, that you snore on most nights?	Yes	No	Not Sure
Have you been told you stop breathing or struggle to breath in your sleep?	Yes	No	Not Sure
Are you tired, fatigued, or sleepy on most days?	Yes	No	Not Sure
Do you have acid indigestion or high blood pressure (or use medication to control any of these conditions)?	Yes	No	Not Sure
Are you overweight?	Yes	No	Not Sure
Score			

ADD ALL THREE COLUMS TOGETHER _____

CALCULATE OSA RISK

4 or higher = high risk for OSA
3 = moderate risk for OSA
2 or less = lower risk for OSA

ATTENTION MEDICARE PATIENTS

All Medicare weight loss patients must sign attached ABN.
Thank you!

A. Notifier: Ventura Advanced Surgical Associates

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Nutrition counseling CPT 99401-99404 Risk factor reduction services CPT 99401-99404 Yearly bone density study CPT 77080	Non covered services	3900.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.